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ABSTRACT

A special report of the National Health and Education Consortium developed for health professionals, this document provides information necessary to promote the provision of adequate health services in elementary schools. In addition to an executive summary, introduction, and conclusion, the report is divided into four major sections. Section 1 defines school-based and school-linked health centers and discusses basic preventive health services. Section 2 addresses the question "Why 'elementary' school-based health centers?" This section provides a rationale for the existence of such centers and discusses how elementary school-based health centers fit into the school's primary function. Section 3 describes how schools work. Among the topics covered in this section are aspects of local administration (dealing with local school districts and school boards, with the Superintendent and other high level officials, with teachers, and with school nurses, for example), and federal and state level educational policymakers. The last section discusses how a health care professional can work effectively within the school system. Specific matters covered in this section include how to: (1) gather the appropriate information to run a campaign for school-based health centers; (2) seek helpful feedback from the appropriate persons; (3) design collaborative activities; and (4) generate broad support. Contains 10 references. (JW)

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Where the Kids Are:

How to Work with Schools to Create Elementary School-Based Health Centers

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We would like to thank the Honeywell Foundation for its generous financial support of *Where the Kids Are: How to Work with Schools to Create Elementary School-Based Health Centers, A Primer for Health Professionals*. We also would like to thank the National Association of Community Health Centers for partnering with us and for providing additional funding for this report.

Large sections of this report regarding how schools work and how to work with schools have been excerpted from *Bridging the Gap: An Education Primer for Health Professionals* [prepared by Candace Sullivan of the Center on Effective Services for Children, and based on the National Association of State Boards of Education publication, *How Schools Work and How to Work with Schools*, co-authored by Janice Earle, William Kane and Candace Sullivan] in *Bridging the Gap: A Health Care Primer for Education Professionals/An Education Primer for Health Professionals*. Washington, DC: National Health & Education Consortium, 1992.

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National Association of
Community Health Centers, Inc.

Dear Reader:

Our association represents 800 community, migrant and homeless health centers that provide comprehensive preventive and primary care to medically underserved communities and populations.

Located in inner cities and isolated rural areas with high rates of poverty, health centers serve many women of child-bearing age, children and low-income families both on Medicaid and without health insurance.

In a 1991 survey of health centers, among the most urgent problems reported in health center communities were teenage pregnancies, infant mortality, substance abuse and nutritional problems.

In order to reduce these and other health problems of children and youth in health center communities, some health centers had pioneered school-based health centers a decade ago. To promote increased cooperative relationships between health centers and schools aimed at making primary health care services more accessible and improving the health of our youth, the National Association of Community Health Centers (NACHC) entered into a cooperative agreement with the Centers for Disease Control and Prevention (CDC) to establish an Adolescent and School Health Initiative. Through this initiative, NACHC provides information, training and technical assistance to health centers to assist them in developing and strengthening school-based and -linked health programs.

A recent survey of health centers conducted as part of this initiative identified 123 health centers that provide some type of health service in cooperation with schools, with half of them reporting services to elementary school children. Fully 75 percent of 332 health centers that responded to the survey indicated that they were interested in initiating school health services.

We are pleased to collaborate with the National Health & Education Consortium and the Honeywell Foundation to make this report available. We recognize that providing health services in schools requires working relationships between distinct institutions with their own ways of doing business. We hope that this report will help health centers and other health professionals better understand how to approach schools successfully. We also hope that schools will become interested in reaching out to community, migrant and homeless health centers in their communities if they have not done so to invite them to develop collaborative service projects.

Sincerely,

Freda Mitchem, *Project Director*
Adolescent and School Health Initiative

Darryl Burnett, *Project Manager*
Adolescent and School Health Initiative

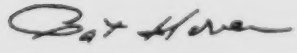
Preface

For a number of years, the Honeywell Foundation has supported work on the health/education connection. Last year, we funded the report, *Starting Young: School-Based Health Centers at the Elementary Level*, a report produced by the National Health & Education Consortium (NHEC) in conjunction with the National Association of Elementary School Principals. The report was novel not so much for what it said, but for its audience — *Starting Young* was written for the school's CEO, the principal — the man or woman in charge of assuring that the school site, staff and curriculum meet the needs of students. What's more, it was produced and distributed by the national association to which most elementary school principals belong. We believe that this approach — addressing the issues most germane to leaders and change agents by partnering with their national associations and tapping their traditional communications lines — will help make interdisciplinary health/education work a reality.

This year, the Honeywell Foundation is pleased to take another practical step toward helping professionals work together across disciplines to address student health and educational success. This valuable report, *Where the Kids Are: How to Work with Schools to Create Elementary School-Based Health Centers, A Primer for Health Professionals* is an effort to answer the questions that health professionals may have regarding how to work with school systems to establish appropriate school-based health center initiatives in their communities. As with *Starting Young*, this report is a resource for thinking about the "what, why and how" of cross-sector partnerships for elementary school-based health initiatives.

Prevention and early intervention will be the answer to assuring that our children are healthy and educated to their full potential in the coming century. Beginning with prenatal care and early childhood immunizations, we must ensure that our nation's children arrive at school healthy and ready to learn. Likewise, we must apply the principle of prevention once children are in the schoolhouse as well. Elementary school health can help sustain the gains of prenatal care and programs like Head Start to ensure that students are healthy and ready to learn to their fullest potential.

Community and migrant health centers are vital partners in this interdisciplinary process, and together schools and health care providers can make a difference in the lives of our nation's young students. We must make every effort to encourage cross-sector collaboration because, as has often been noted, while children make up only 26 percent of our population today, they make up 100 percent of our future.



Patricia Hoven
President, Honeywell Foundation
Vice President, Community and Local Government Affairs, Honeywell, Inc.

Foreword

Since 1990, the National Health & Education Consortium has worked to foster linkages between the health and education communities. We see this connection as critical to promoting a healthy citizenry whose minds are receptive to learning and whose bodies are sound for a lifetime. Elementary school children are one of the most important populations on which our efforts should be focused.

It is vital that these young children come to school mentally and physically ready to learn. School-based health centers represent a unique opportunity to identify and potentially address some of the problems that we know impact a child's ability to learn. We need to identify vision, hearing, nutritional, dental and other problems that impact a child's learning at the earliest possible age. And, to the extent possible, we need to address these problems quickly and comprehensively.

The National Health & Education Consortium hopes that *Where the Kids Are: How to Work with Schools to Create Elementary School-Based Health Centers, A Primer for Health Professionals* will provide you with the information that you need to promote or enable the provision of health services in the elementary schools in your community. The first section of the report answers the questions, "how does the educational system operate and how can health professionals work effectively with school staff?" to provide you with a better understanding of who works in schools, how health is perceived and what to do to assure successful partnerships. This section will also help clarify the rationale for placing school-based health centers specifically at the elementary level.

The last sections of the report are resources regarding the range of supports at the national level for school-based and -linked health centers. They provide descriptions of federal goals and appropriate contacts for further information.

Please feel free to call on the National Health & Education Consortium to assist you in your interdisciplinary efforts to ensure that the children in your community live long, happy and fulfilling lives.

Tamara Lucas Copeland

Tamara Lucas Copeland
Director
National Health & Education Consortium

November, 1995

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Executive Summary

Where the Kids Are: How to Work with Schools to Create Elementary School-Based Health Centers, A Primer for Health Professionals is a resource for health professionals — and especially community and migrant health center staff — for thinking about how schools operate and how to partner with educators and the education system to create elementary school-based or -linked health centers. It is at once a primer on the education system and an information resource on community health center/school partnerships. *Where the Kids Are* provides a definition of school-based health centers; articulates the rationale for starting them at the elementary school level; describes the national, state and local educational systems in the U.S. (in detail at the local level); lists appropriate contacts for further information; and addresses federal goals regarding health/education linkages.

The main thrust of the publication is to help health professionals better understand the educational system and how to work with elementary schools. Today, school-based health is provided predominately at the middle or high school level, underutilizing the critical role of elementary schools.

Where the Kids Are is published in partnership with the National Association of Community Health Centers' Adolescent and School Health Initiative as a companion report to the 1995 National Health & Education Consortium publication, *Starting Young: School-Based Health Centers at the Elementary Level*, which was aimed toward elementary school principals and published in partnership with the National Association of Elementary School Principals. Community and Migrant Health Centers are public or private, non-profit community-based health care organizations which provide comprehensive preventive and primary health care services in medically underserved communities and to medically underserved populations.

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Where the Kids Are:

How to Work with Schools to Create Elementary School-Based Health Centers

Introduction

A growing number of health professionals and organizations view schools as critical partners in their efforts to improve young people's health, and are attempting to forge alliances with educators. These efforts are occurring in light of increasing understanding that health and education are related.

Educators know that health influences learning. Children who are hungry, have trouble seeing or hearing, lack energy, are distracted or use drugs need special attention and often do not learn as well as healthy children. By the same token, health care practitioners know that education can promote children's health. If women learn not to smoke, drink or use drugs while they are pregnant; if parents know how important it is to get their child immunized; and if children themselves realize the value of good nutrition and healthy lifestyles, it is likely that our nation's children will be healthier and better able to reach their full educational potential.

Over the past several years, discussion among educators and health professionals alike has moved from, "Is there a connection between a child's health status and education?" to "How can health professionals and educators collaborate to ensure children come to school healthy and ready to learn?" School-based health centers are one answer to this question.

In particular, school-based health centers at the elementary level are fast emerging as a model of cross sector cooperation. As with all efforts involving children, it is beneficial to begin early both with health care and with health education efforts. Elementary school health care can help sustain the gains of prena-

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tal care and programs like Head Start to ensure that students are healthy and ready to learn to their fullest potential.

Yet, it is often difficult to get those who agree on the relationship between education and health to work effectively to implement new services that address this interdisciplinary reality. Each field increasingly acknowledges that in promoting the optimum development of a child, health and education are inextricably linked. However, these worlds remain far apart. Even though education and health professionals need each other to be fully effective, all too often health professionals who want to work with the education system — and educators who want to work with the health care system — end up puzzled and frustrated.

In order to facilitate a working relationship between community health providers, schools and advocates, NHEC has produced this primer for health professionals on how to work with educators to create school-based health centers at the elementary level. It is intended to help health care providers answer some basic questions about the educational arena. How does the educational system work? How is it governed? Who is in charge of what? If one wants to work with a school, how does one go about it? Even for those who have tried working with schools, there are often questions. How can we in the health professions get schools to work actively with us in achieving public health objectives? How do we gain access to students? Why are some of our offers met with resistance? Why are health issues considered so controversial? These are some of the questions that this report will help answer.

Defining School-Based and Linked Health Centers

It will be helpful to briefly define what is commonly meant by the terms "school-based" and "school-linked" health center.

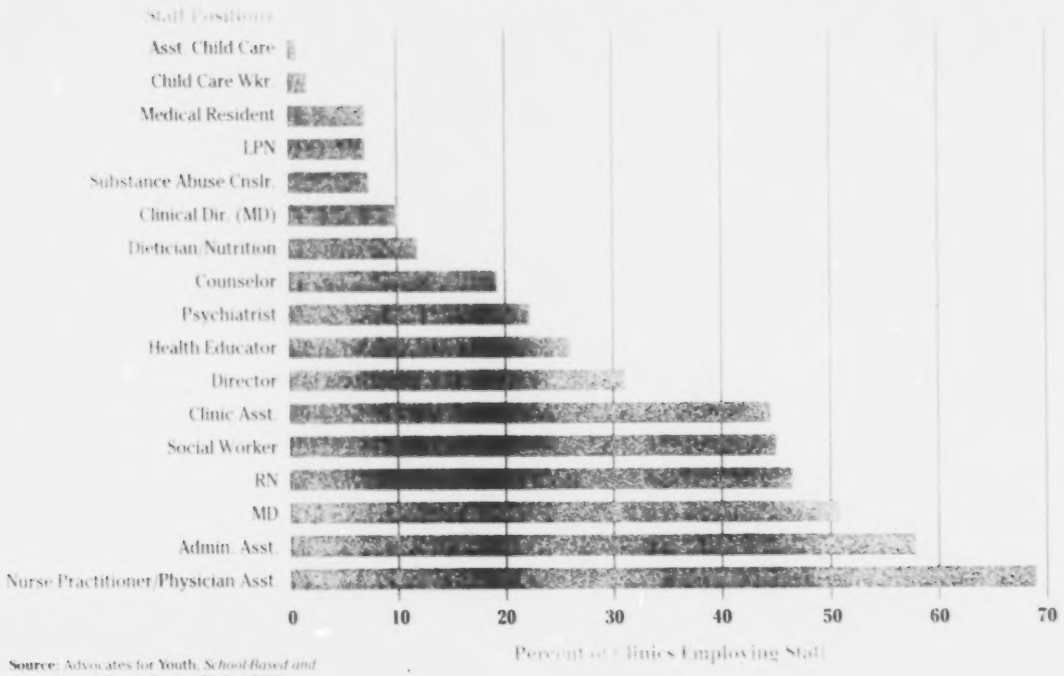
School health services provide students with comprehensive primary preventive medical, social and mental health services, delivered by multi-disciplinary teams of professionals, including school nurses, nurse practitioners, physicians, social workers, and educators[1] (see Graph 1) in or near the school building. Because school-based health centers focus on comprehensive health service delivery to children in school, they differ from common health support services (such as health screenings), comprehensive school health education programs, or projects where health is only a small component of a larger service integration initiative. There are two types of school health centers — those that are school-based and those that are school-linked. More specifically, the following definitions help distinguish between school-based and school-linked centers:[2]

School-Based Health Centers
A school-based health center (SBHC) is a health center located in a school or on school grounds that provides, at a minimum, on-site primary and preventive health care, mental health counseling, health promotion, referral and follow-up services for young people enrolled. The key element is *location in a school.*

School-Linked Health Centers
A school-linked health center (SLHC) is a health center located beyond school property that serves one or more schools. The center may also serve young people from the area who are not students. Services include, but are not limited to, primary health care screening and treatment, mental health counseling, health promotion, referral and follow up. The center usually has formal or informal ties to the schools — including accepting referrals from school per-

Graph 1. **Staffing of School Health Clinics**

School-Based and -Linked



Source: Advocates for Youth, *School-Based and School-Linked Health Centers, Update 1993*

sonnel, providing priority appointments for students, marketing the services of the center in the school and/or offering classroom health education. A formal letter of agreement may or may not exist between the health center and the school. The key element is *location off school grounds*.

In addition to school-based and -linked health centers, the concept of school health services includes another component:

Basic Preventive Health Services[3]

A school-based or -linked health center may provide basic health education and health promotion activities as well as screening and related preventive services in the school setting, but not actually provide comprehensive primary care.

School-based health centers are part of a larger, ongoing "service integration" movement that has resulted in response to the current fragmentation of services for children. The service integration movement itself calls for coordinating and collaborating services so that the emphasis of each agency is shifted from itself to its clients: the child and the family.[4] The movement to create school-based and -linked centers in particular focuses on health, education and social services working together more effectively.

A Brief History of School-Based Health Centers

The idea of providing health services to children in school is not a new one, but delivering comprehensive services on-site is. The history of school-based clinics is largely undocumented, but dates back to the origins of public education in the 1840s, when specialists debated whether or not to provide health services in the schools.[5] The debate was partially resolved in the 1890s, when health programs were introduced into the schools in response to the large numbers of immigrant children who, because of cramped and unsanitary living conditions, often came to school suffering from infectious diseases such as tuberculosis. Most of these early school health efforts concentrated on prevention. Mobile physician inspectors visited schools, focusing upon hygiene and occasional immunization.

School district physicians were eventually replaced by the more permanent presence of a school nurse. The role of the nurses varied from location to location, but, over the years, the presence of nurses in schools became a standard feature in many school districts, demonstrating the degree to which educators have become dedicated to school health. Although in the past, direct treatment had been administered within schools, in the 1930s, schools began to sponsor a more limited program of health screening and first aid, relying on referrals to private settings for actual treatment. At this time, boards of education — not traditional medical institutions — controlled school health services.

Fueled by new concerns for student health in the 1960s, in 1970 the federally-funded Children and Youth Project of the University of Texas Health Science Center Pediatrics Department began the first high school-based clinic. Following suit, in 1973, Dr. Laura Edwards and other members of the Maternal and Infant Care Project of the St. Paul Ramsey Hospital opened a comprehensive school-based health clinic in Mechanic Arts High School in St. Paul, Minnesota. This famous clinic was the first to provide comprehensive services. When that school closed its doors, the clinic followed its students to two other schools, eventually expanding to two additional school sites as well.

By the late 1970s, the Robert Wood Johnson Foundation began a national school health program to document the feasibility of providing primary health care in the school setting. In 1986 the Foundation began funding 24 high school - based centers through its "School-Based Adolescent Health Care Program." During the following years, the Foundation also funded nurse practitioner positions in schools in four states. Currently, the Foundation supports grants to 12 states through the nationally-recognized "Making the Grade" program.[6]

In 1994/95, the National Association of Community Health Centers documented 123 community and migrant health centers offering services in cooperation with schools. Also in 1994, the Bureau of Primary Health and the Maternal and Child Health Bureau funded the "Healthy Schools, Healthy Communities" initiative, providing the first direct federal support program for school-based health centers and services. Many of the "Health Schools, Healthy Communities" grantees are community and migrant health centers.

Thirty years ago, the school-based health center was a fledgling model for cross-sector collaboration. Today more than 600 school-based and school-linked health centers are operating across the country,[7] and the number is growing each year.

For further history on the school-based health movement, NHEC recommends that you read Joy Dryfoos' new book, *Full-Service Schools: A Revolution in Health and Social Services for Children, Youth and Families*, which is referenced at the end of this report.

Assuring Success

Beginning a project like this—one that is so complicated and individual to a community—is hard. Yet, common themes do run across school health projects. We've found that it is important to brainstorm and share ideas with others; it not only saves time and effort but it helps you realize you're not alone.

—Gabriel Works
Cherry Street Health Services

Planning for and starting a school-based health center is only half the game. It is important that the center be a successful addition to the school community and that you are valued as a partner in the educational success of students. In discussions with community health centers, the following themes have emerged regarding how to assure ongoing success when working with schools:

- Talk Early and Often
- Don't Assume Everyone Knows What You Are Doing
- Involve the School Nurse
- Think About the Future
- Focus on Financing

Throughout this report, these lessons will be highlighted in boxes like this one, providing commentary from the field on the lessons shared in the text.

Why *Elementary* School-Based Health Centers?

It is important to review why, in particular, a community or migrant health provider might wish to work specifically at the elementary school level.

Although there has been a growing proliferation of the school-based health center model of health care delivery (see "A Brief History of School-Based Health Centers") most school-based health centers are located in high schools or middle schools and focus on adolescents. Yet, educators, health practitioners and policy makers alike are now beginning to realize that we must turn our attention to younger children as well. The strategy of prevention requires that we start in the early years to ensure maximum benefit for students.

Rationale

Statistics show that by the time students enter middle school, many have developed unhealthy habits and conditions that should have been addressed at a younger age. According to recent studies, the peak ages for initiation of cigarette smoking is in the sixth and seventh grade;[8] thirty-seven percent of eighth graders report having used alcohol by the end of the sixth grade;[9] and one out of every twelve children under age twelve is hungry[10]. The concept of placing health centers in elementary schools — which have demonstrated ability to reach young children *and* their families in the community — has compelling rationale:

Schools Are Where the Kids Are. It is becoming an adage and it's true — schools are where the kids are, and in many communities schools are the only institutions with the social penetration necessary to reach most young people.

Parental Involvement. Many parents and other primary care givers still accompany children to school at the elementary level and maintain regular interaction with the school during the school

year (something to be encouraged and capitalized on). Parents play a vital role in ensuring compliance with treatment for their children, influence health behaviors, dictate nutritional choices, etc. The level of parental involvement in the elementary years also affords center staff the opportunity to help educate parents about their health and the health of their children.

The Whole Child. The elementary school years are an ideal time to address the needs of the whole child, because a range of existing services can be brought together in a known environment for the child.

Putting the "Early Intervention" Into Prevention. Prevention and early intervention are key strategies for alleviating the need for more costly and even stigmatizing services later.

Bridging the Gap. Nationally, we invest far too little in children and youth's health and educational needs. An elementary level focus is critical to maintaining the benefits and gains of earlier programs (e.g., Head Start, WIC, etc.), which will dissipate without reinforcement; to maintaining children's interest in health; and to teaching students the skills necessary to access health care services as they become adolescents and adults.

How Do Elementary School Health Centers Relate to a School's Primary Function?

Before discussing how to work with schools to create partnerships for SBHCs, it is important to address one of the most commonly asked questions — and most misunderstood issues — surrounding school-based or -linked health centers: will the health center detract from a school's primary function?

Few school health advocates believe that schools or students will benefit from making the delivery of health and social services the sole responsibility of schools. Already overburdened, teachers need help educating children, not additional pressures and regulations. Schools are being asked to address issues affecting student health such as lack of student access to health care and/or inadequate health care services, poor nutrition, teen pregnancy, alcohol and drug abuse, prevention of AIDS and other sexually transmitted diseases, anti-social behavior and suicide. Educators are called upon to assure students receive health status assessments and immunizations and that children with special needs receive medication and other essential health care.

That is exactly what elementary school-based health centers are designed to do: help educators achieve their mission by addressing the social, physical and emotional health problems that interfere with children's learning.

In fact, the influential Committee for Economic Development — a national alliance of major corporate leaders — has stated explicitly and eloquently that:

> By both decision and default, much of the burden of dealing with a vast array of social problems has been placed on the public schools. Many look to the school instead of to parents and the community as the front line of defense against every social or health problem from teen pregnancy to child abuse, AIDS, violence and religious disaffection.
>
> No organization can traverse such a swamp of conflicting missions ... Community problems need to be addressed through community-driven services and institutions. These services may be *placed* in the schools, they may be *delivered* through the schools, but they should not be made the *responsibility* of the schools.[13]

Elementary school-based or school-linked health centers are an answer to this dilemma. They are a proven tool for forging a partnership between the school and the community to reach and help children toward the end of bettering their educational status. School clinics do *not* detract from the school's primary mission — learning — rather, they help protect it.

Traditional Health Concerns of Schools

The education sector has long been interested in the health of its students. For example, the nation has had nurses in public schools since Lillian Wald's "month long experiment" in the New York City schools in the early 1900s. However, the level of attention paid to student health concerns has varied over time and is by no means uniform from district to district. Certainly, the notion of school-based health centers *per se* is a recent phenomenon (see "A Brief History of School-Based Health Centers").

Traditionally, the school's concern for the health of students has manifested itself in four broad areas:

Health Education — includes the curriculum and instruction related to good health knowledge, skills and practice. In 1990, 42 states required that health education be provided in schools.[11] Of these, 28 required a planned and sequential program of "comprehensive health education" addressing a range of health programs and issues.[12] Some health education occurs during special events (health fairs) and in conjunction with other school programs (food service, physical education).

Physical Education — includes physical activity programs that foster lifelong exercise habits and constructive recreation opportunities.

Health Services — includes initial health screenings and referral activities and record keeping to comply with state laws such as maintaining immunization records. In some schools, staff also dispense medication or perform specialized medical procedures and otherwise minister to children with special health needs, administer first aid and provide counseling and education related to individual health problems.

Healthy School Environment — includes the school facility itself and activities aimed at providing students with a healthy environment in which to learn and grow. This component includes a school climate that is emotionally and intellectually nurturing, wellness programs for school personnel, food services that reinforce healthy eating behaviors, good sanitation, heating and lighting, and provisions for student safety such as emergency procedures and security.

How Schools Work[14]

Public education is a massive yet decentralized and diverse enterprise. It is a shared responsibility between local, state and federal governments, with multiple actors at each level. Thus, schools must operate under three levels of rules and regulations as well as meet parent and community expectations. The result is an extremely complex structural and political web that is difficult for educators, much less health professionals, to negotiate.

Not only is the education sector built of a complex arrangement of levels and responsibilities, schools are often almost entirely separate from the rest of government. This makes for confusing times to those in other sectors who approach education-based initiatives expecting schools to behave like other governmental entities. The history of this separation has been well summarized by Dr. Michael Usdan, a longtime observer of the educational system:

> Early in this century, municipal reformers spearheaded the movement to create a separate governance structure for schools in most jurisdictions. Schools were deemed to be of singular importance in socializing and shaping ... civic attitudes and vocational competencies .... Indeed, they were considered to be so vital that local school boards were institutionally separated from general purpose government so that their members would be "untainted" and insulated from the more blatant abuses of partisan politics and patronage that were so rife in urban centers in the early 20th century. This institutional separation was embedded in state law. For example, school statutes were codified separately from other legislation, and school board elections in most states were mandated to be held at different times from general elections.[15]

As Dr. Usdan notes, cross-sector collaboration is "often impeded by the current institutional separation of schools from other governmental entities and the attendant lack of communication among agencies that must work cooperatively if the lives of many children are to improve."[16]

The Local Level

Although education is legally a state-level responsibility, the most important arena of the nation's educational system is the local level. It is at the local level that most health professionals will concentrate their work with teachers and schools to establish school-based health initiatives. Likewise, local level school boards, administrators and teachers will have the greatest impact on the success of any individual school-based health center. Below are described the school system structure and some of the most influential organizations and individuals in any local education system.

Local School Districts. A local school district is an area of a state that serves as the unit for administration of a public school system. School district boundaries do not always coincide with boundaries of other governmental jurisdictions. A school district may serve more than one municipality or county, or a section(s) thereof. There are nearly 15,000 local school districts in the Unites States.[17]

Local School Boards. States and localities have charged local school boards with governing public education in local school districts. School boards were founded on the belief that local citizens should control the policies that determine how children are educated. Local school boards operate in many jurisdictions with full fiscal independence, often with their own taxing power. Relations among local school boards and general city government can sometimes be strained over political and/or financial conflicts.

In most school districts, local school boards hire the superintendent and make many of the policies that are implemented by the superintendent and the local education agency. Increasingly, they are expanding their overall management role.

Local school board authority, however, is not complete. Constitutionally, education is a state responsibility. Therefore, local districts are subject to state policies that may direct, limit or otherwise influence local policy making and implementation.

TALK EARLY AND OFTEN

If you don't have them [administration and key staff] on your side, you might as well not be there.

— Antonio Gurle
Valley-Wide Health Services, Inc.

It is important to speak early and often with the school administrator and key staff about problems, successes and plans for the future. The principal has a lot to do and is often torn between putting out the day-to-day fires that emerge and planning for the continuation of services. Key steps to talking early and often include: drafting a list of services to be offered and sharing it with the principal and establishing a regular vehicle for communicating (e.g., update meetings with administrators and teachers, or regular meetings of a planning and/or oversight team).

Similarly, school boards that accept federal funds are required to adhere to federal policies and regulations. Furthermore, some local school boards are required to work with the Mayor and City Council when these bodies have budgetary authority. In such a case, the Mayor or Council Chair may, in fact, be the most important figure on the local education landscape — a situation especially true in some big cities, as the recent brouhaha in New York City has illustrated.[18] It may be important, then, to spend time building advocates for a school-based health center in the Mayor's office or within the city council itself; and it is certainly critical to determine who may oppose school-based health services in the local government.

More than ninety-five percent of school board members in the U.S. are elected.[19] The remainder are appointed, usually by elected officials, such as mayors, county officials, and governors. School board members are strongly influenced by what they perceive to be constituent values and interests. The diversity of these constituencies, particularly in urban areas, sometimes makes it difficult for board members to pursue a common vision and strategy, particularly on what are perceived as controversial health issues. This enables organized special interest groups to assert significant influence on board policies and programs.

As was illustrated in the excerpt from Dr. Usdan's article (above), the relative independence of local school boards from general purpose government agencies and community power structures poses challenges for collaborative activities among the health and education communities. Few communications systems and virtually no joint or linked operational systems are in place between school districts and health departments, child care and social service agencies, and protective and juvenile services. As a result, there is the potential for both overlap and neglect in the provision of social and health services to children. In some localities, however, school districts and general purpose government are beginning to promote interagency, interdisciplinary collaboration as a way to provide more efficient and effective services for children and families.

Superintendent. The superintendent is the chief executive officer of the local school district and is responsible for implementing education policy. As discussed above, most superintendents are hired by the local school board. The main exception is in the South where a number of superintendents are elected.

There are a number of "grey areas" between a board's policy making authority and a superintendent's administrative responsibilities. The tendency of some boards to become immersed in the day-to-day administration of their districts

often results in tension between the superintendent and the school board. Conflict between boards and superintendents is one reason that the average tenure for a big city superintendent of schools is less than three years.[20]

Central Office. Superintendents have administrative and support staff to assist in program development and implementation. The size of the central office staff depends on the size and the resources of the district. Current budget crises are pressuring local school boards and superintendents to reduce central staff in order to be able to maintain fully staffed schools.

Larger districts may have central office staff with responsibilities for health curriculum and instruction, physical education, HIV/AIDS education, drug/alcohol/tobacco education, health services, and special education (education for children with special needs). Many health-related staff positions and school health programs are paid for with state and federal categorical program funding.[21] Categorical funding is restricted funding — that is, it can only be used for specific populations (e.g., bilingual children) or specific programs (e.g., drug abuse prevention programs). Staff and programs supported through federal and state categorical funds are generally protected from local budget cuts, but are among the first to be eliminated when federal and/or state funding ends.

Education Unions. Many school districts have active teacher's and administrator's unions. The National Education Association (NEA) has the most affiliates nationwide. However, most teachers in large districts are affiliated with the American Federation of Teachers (AFT). Unions represent front-line workers in education and can be key allies or formidable opponents to health-related programs in the schools. It should also be noted that, in addition to teacher and administrator unions, there are unions for maintenance, transportation, food service and other workers that could affect school-based health centers.

Local Schools. The best place to reach children and youth is at school. The most effective schools have strong administrative leadership, a school climate conducive to learning, a school-wide emphasis on instruction, high teacher expectations for student achievement, systemic monitoring of pupil performance, and a high degree of parental involvement.

Low income and minority students are particularly vulnerable to social, emotional and physical health problems that can interfere with learning and lead to health-risking behaviors and unhealthy lifestyles. School-districts or schools serving large numbers of such children greatly benefit from partnerships with health professionals.

Depending upon the district, individual schools may or may not have considerable autonomy. In recent years, there has been a growing movement towards site-based management. This has resulted in a transfer of authority for certain policies and programs from the central office to school councils. Typically, these councils are comprised of the principal, teacher(s) and other staff, parents and community representatives.

Principals. Depending upon the school and district size, each school has a principal who supervises the school's instructional program, maintains order and discipline, evaluates teachers, represents the school to parents and the community, and represents the school at athletic and other special events.

The principal can either actively support or oppose the provision of health services in schools. A principal with vision and leadership can inspire and guide the entire school staff towards achieving health objectives. Conversely, an opposing principal can be a serious obstacle to progress.

Assistant/Vice Principals. Elementary schools are likely to have just one assistant or vice principal, but this administrator may have more influence than their counterpart at a middle or high school

✓ List for Discussions with School Administrators

This check list is offered as a brief guide to determining the "readiness" of school leadership to engage in a school-based health center initiative. It is important to gauge a principal or vice principal's familiarity with and attitude toward school health as you begin planning for an SBHC.

Health Needs
Does the principal understand the role that health plays in ensuring educational success? It is important to gauge the principal's awareness of student and community health needs (indeed, do they have an accurate sense of the health status of the student body?), and their understanding of the distinctions between health education, health care referral, preventive activities and care services.

Health Outcomes
Has the principal had any experience working with students to improve health outcomes? Possible past experiences might include arranging to dispense medications, assisting students with chronic disabilities, or ensuring immunizations.

Health Staff
Has the principal hired and/or worked with health staffers before? Does the school have a school nurse, mental health worker or other care professional? What are the principal's beliefs regarding the need for and efficacy of these care givers? What sort of role does the school administration play in terms of supporting health professionals? Does the principal work with outside health providers to provide student care? How does the principal feel about *supervision* of staff? Will he or she want to supervise the health staff operating on school property? Will the principal accept health agency supervision of health personnel? Will there be some form of joint supervision? This issue is a critical one.

Politics of Health
Has the principal dealt with health issues in his/her negotiations with the school board? What is his/her sense of how health issues sit with board members? Does the principal seem to have a good rapport with the school board and the community in the area of student health?

Health Programming
Does the school currently use a health education curriculum? Has the school been a site for a health fair or immunization campaign? Is the school environment an active concern of the principal? Is the principal supportive of staff wellness?

Don't Assume Everyone Knows What You Are Doing

We work with an advisory board which consists of two school staff — usually teachers; two parent representatives; and two students. They are critical in getting information out.

— Stephanie Montgomery
New River Family Health Center

The school administration is certainly critical to a school-based health center's success. However, it is a mistake to assume that talking to the principal or the school nurse alone will assure that teachers and other staff are kept up to date on the center's activity. It is necessary that you and the center staff approach teachers, support staff and other school professionals such as the physical plant manager and the school food service personnel directly (with the administration's knowledge and approval). Consider such regular avenues of contact as staff training, periodic updates at teacher meetings, and/or briefings for the school board and parent organizations. The health center is primarily your organization's responsibility and you will most likely be the lead organization with regard to meeting standards, requirement and staffing needs; likewise, it is primarily your obligation to be sure that everyone knows what is happening.

where there may be up to five assistant principals responsible for a range of school concerns. It is important to include a vice principal in planning for and overseeing a school-based health center. Like the principal, a vice principal may be a valuable supporter or a serious foe to school health services. Often, a principal will ask the vice principal to act as his or her liaison to a school health initiative.

Teachers. Teachers and other instructional personnel have many important roles to play in improving student health and can cooperate well with school-based health centers if they are properly involved. Teachers are primarily responsible for daily classroom instruction — within state and district guidelines. Elementary school teachers generally teach approximately twenty-four students for a full day.[22] The exception is when they are "team teaching," in which case they have joint responsibility for approximately fifty students. Teachers at all levels are certified professionals; many have graduate degrees.

Resource Teachers. Resource teachers are responsible for working with special populations (such as special education, learning disabled, disadvantaged and other special needs students). These teachers may work with students in self-contained classrooms, serving special needs children exclusively; in resource settings, requiring the special needs student to leave the regular classroom to join the resource teachers for a short period of time; and in regular classrooms with a mix of students, working directly with special needs individuals or small groups of special needs students.

Paraprofessionals and Classroom Aides. These staff are responsible for assisting the teacher in the routine conduct of class activities, sometimes working with small groups of students on particular projects or even performing very specialized medical procedures in special education settings. Aides may be assigned to work in specific classrooms or with specific subject matter. The number of students they interact with daily is subject to local regulations.

Other Professionals

School-based curriculum specialists are responsible for providing extra support and guidance to teachers in particular subject areas, especially at the elementary and middle school levels.

Counselors are responsible for class scheduling, college counseling, career counseling, academic counseling and personal counseling. Some counselors serve more than one school. Most counselors have little in-depth contact with students.

Librarians are responsible for coordinating learning centers with teachers, as well as working directly with students.

School-related personnel. Included here are secretaries, custodians, cafeteria workers, bus drivers and crossing guards. Because these individuals have frequent, informal contacts with students, they are often very well acquainted with what is going in students' lives and in the school.

School Nurses[23]. School nursing represents the nation's oldest and most knowledgeable cross-sector health/education profession. School nurses are responsible for conducting health screenings, maintaining health records and providing emergency services. Nurses sometimes provide one-on-one health education to students and serve as a health resource to teachers and other school personnel. Some school nurses are employed by the school system and others by the local public health agency. About half of all schools have access to professionally trained school nurses, but many of these nurses work part-time at several schools. Similarly, nurses assigned to schools by the Department of Health usually serve multiple schools.

Due to the nature of school health services, legislation and current school nursing practice, numerous professional-legal dilemmas regarding scope of practice for school nurses have emerged. As a result, many school nurses have limited responsibilities regarding provision of

INVOLVE THE SCHOOL NURSE

We developed clearly defined, complimentary roles for the school nurse, the nurse practitioner and the community health nurse. This allowed them to provide a continuum of services for the kids.

—Nancy Hook
Clinica Adelante, Inc.

Perhaps the most important school-based professional to the daily success of a school-based health center is the school nurse (assuming, of course, that a school is fortunate enough to already have one). It is therefore important to respect the school nurse's position and enlist support early on. Once it is clear that the center is supportive of school nursing, you may find that the school nurse is a valuable advocate for the center, helpful in planning for the center's operation and essential to the success of referral mechanisms and other operational concerns. Directors of successful school-based health centers regularly cite the importance of good center staff/school nurse relationships to the center's activity and acceptance in the school. Of course, if no school nurse is present, the center can still become a valuable addition to the school. Some school nurses are employed by health departments rather than schools and therefore center staff must become adept at working with a number of bureaucracies at once. At its best, a school-based health center relies on the school nurse for assistance and advice and helps the school nurse reach and treat more students more effectively.

health services. The school nurse is, however, the most important health representative in the school and a critical partner in any school health initiative. In fact, the school-based health center often allows school nurses and the health center's staff to interact as partners, greatly enhancing their respective impact on student health. School nurses should be involved early in planning for a school-based health center, can provide valuable insight into the politics of school health at the local level and are critical members of a health center's oversight team.

Parents. Parental involvement in schools varies considerably. Nearly all schools have parent-teacher organizations that provide a variety of services and support. For example, they will sponsor fund-raising projects such as bake sales and host events that connect teachers and parents such as monthly parent-teacher assemblies. Educators have long recognized the importance of parents and other family members in fostering student achievement.

Today, an increasing number of schools are placing even more emphasis on the value of parents as partners and first teachers and are modifying their programs accordingly. In some schools, parents are encouraged to offer their opinions on various school policies and programs as members of various advisory boards and school improvement committees. Where school-based management exists, parents may actually participate in school decision making through election or appointment to school governing bodies. However, not all schools have effective structures for engaging parents in the life of the school. The school-based health center may need assistance from neighborhood leaders or community-based organizations to understand how to constructively involve families in planning and implementing center activities.

Parents are essential partners in school health programs and other activities to improve student health. They tend to be enthusiastic and supportive. Parents need to be consciously included in planning activities to design and implement such programs.

Understanding Ambivalence: Selling Health to Educators

Many schools welcome outside efforts to assist with student health. However, not all offers on the part of health organizations are met with open arms by educators. Do not take it personally; it may be that these educators are preoccupied with their main objective: the academic training and performance of students. Many in the education community have not yet recognized the interrelationship between academic performance and student health.

What's more, education is currently under siege. Large numbers of educators are under heavy pressure to make major changes in traditional school concerns such as curriculum, instruction and organization. They are under attack from members of the policy, religious, and business communities (and others) for graduating students who are not well-enough prepared to participate in a changing nation and world. Educators today are facing great pressure to promote better academic achievement and higher performance on standardized tests. Health may not be high on their reform agendas.

Inattention to health issues is not surprising in any case. Student health traditionally has not been viewed primarily as a school responsibility. Many educators and policy makers are not yet convinced that schools should become actively involved in student health issues, although they acknowledge that good health is a prerequisite to academic success. Even recent reforms like the National Education Goals[24] have not included health explicitly.

Finally, school districts must continually address an overwhelming number of issues, from contract negotiations and redistricting to shrinking resources and physical plant upkeep and construction. School boards may be reluctant to add school health programming to their already full agenda unless they perceive student health to be a particularly urgent problem. The education sector will need your considerate and persistent help to recognize the importance of health to educational success and to design and implement appropriate school-based health services.

Health professionals can engage in any number of activities to help educate educators to child health issues and the importance of health in ensuring a child's academic achievement. You can, for example, offer to speak at teachers' meetings about the health status of the community; the prevalence of health insurance among students and the relationship between insurance and access to health care; the range of (or lack of) service providers in the community; the rationale behind preventive health initiatives; and the relationship between physical and mental health and a child's readiness to learn. Health providers can share written materials; meet individually with teachers, administrators and board members; and offer their expertise as resources to educational decision makers. Think creatively about how to build a relationship with the education sector while providing its professionals with needed information.

The State Level

Constitutionally, states are responsible for public education. The state education policy development process is complex, involving the state board of education, the governor and legislature. The chief state school officer and the state education agency play influential roles in proposing policies and programs for implementation. State boards typically set graduation standards, establish teacher certification requirements, adopt textbooks, and develop assessment programs to ensure that school districts and schools perform at acceptable levels. State boards set certain health-related policies. For example, they can require that all students receive family life education or have daily physical education. The actions of governors and state legislators increasingly govern state boards of education and chief state school officers, who are responsible for translating state policies set by the legislature into programs and regulations.

To date, seven states[25] have responded to a national "Joint Statement on School Health" signed by the Secretaries of Education and Health and Human Services (see "The Federal Level," below). By recognizing the importance of cooperation at the agency level either by expressing their support of the Statement or by signing one of their own, state-level leaders are further paving the way for official pathways of communication and common action between the education and health sectors.

Naturally, the level of impact you wish to have will dictate how intensive your efforts will be at the state level. Those primarily interested in establishing a local school-based health center will probably be best served by concentrating their efforts at the local level. However, if an initiative aims to make a difference in state policy — for example, in assuring that state MediGrant (the successor to Medicaid) policies and programs support school-based health — or if there are no state mandates for school-based health education or services and it will require state-level support to facilitate local level action, then perhaps working at the state level will and should be a significant component of your work. If your project leads you to the Capital steps, seek the advice of those in *both* health and education who have worked successfully at this level before venturing into statewide educational politics.

If you do choose to work at the state level, consider acting in partnership with state-level professional associations. Professional associations, in both health and education, have a very visible presence in a state's legislative process. Association leaders know a great deal about the concerns of practitioners, pending legislation, which legislators are concerned about health and/or education issues, and how to "work" the political system. In addition, state associations have access to their national offices, which often provide invaluable policy making information and expertise. It is likely that engaging representatives from education and health professional associations will strengthen both your information base and your influence over the legislative and/or fiscal processes with regard to school-based health initiatives.

The Federal Level

The federal government has a limited role in education. Most federal education money is given to states with instructions that it be targeted to economically disadvantaged children and children with special needs. Although the federal government provides only about seven percent of all education dollars,[26] acceptance of federal funding means that schools must adhere to a number of federal regulations and reporting requirements. The federal government also supports a limited amount of research and development in education.

Health services and health education have not been central concerns of the U.S. Department of Education, although the Department does fund drug prevention education. While not primarily concerned with comprehensive health education and other health issues, the Department has increasingly stepped up its efforts to embrace

health and education linkages. Recently, the Secretary of Education and the Secretary of Health and Human Services released a "Joint Statement on School Health" (see Appendix C).

The Department of Education is not the only provider of federal funds to schools. The U.S. Department of Agriculture plays a major role through its school lunch program. The U.S. Department of Health and Human Services supports the Head Start program — a preschool program stressing health, nutrition and family support services as well as other child care and development programs. The Centers for Disease Control and Prevention (CDC) provides funds for states and cities to develop HIV/AIDS prevention policies, plans and programs that involve schools. CDC staff also promote comprehensive school health programs as a powerful way to improve children's health. In recent years, some states and localities have been experimenting with use of Medicaid and the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program funds to reimburse schools and school-linked health centers for certain health services.

Although the federal government plays a small but influential role in education, the bottom line remains — to be effective it is important to know the environment of your local school district. This includes the state policy context, the local policy context, and who in the system is likely to be most responsive to building relationships with health professionals.

How To Work With Schools

Now that you have a general sense of how schools work, you are ready to begin thinking about how to work with schools. How you work will depend in part on what level you are interested in approaching. If you seek to influence the school "system" to create policy regarding the establishment and support of school-based health centers, you will work with district policy makers and administrators. If you seek to establish a health center at a specific school, you will need to assure that the superintendent and school board support (or do not oppose) the establishment of the center as well as work with the principal, school nurse, teachers and local PTA, union representatives and other key individuals. Your approach will likewise vary with your level of experience with the school, your health center's status in the community and your constituency and leadership. Whatever level you seek to approach, whatever community you seek to work in, whatever goal you set, keep these essential rules in mind as you work to partner with the educational system:

- Do Your Homework
- Seek Feedback
- Design Activities Collaboratively
- Generate Broad Support

Do Your Homework
The critical first step in planning a school-based or school-linked health center is to gather background information and implement a needs assessment. It is important to know the following kinds of information:

- **The health status of children and youth in your school and/or community**
  It is important to ascertain the current health status of children and youth in your school and/or community. In some cases, your health center may already have this data as a part of its outreach planning, or the district may have health statistics for students. In other cases, it

may be necessary to go to the public health department or to child advocacy organizations. This information is critical to helping policy makers and administrators understand why the school should play a more central role in health promotion. Ask questions such as: How many students have health insurance?, How many actually have access to services?, Have there been incidents of preventable epidemic disease? What is the average number of days lost to illness at the school?

- **The nature of school or district health policies and programs**

It is also essential to know the status of current health policies and programs in your school district. There should be written district policies and program descriptions. If not, there is usually someone in the central office with responsibilities for school health programs whom you can consult. Ask questions such as: Is comprehensive health education required?, Are students provided with the health services they need?, Is there a mandatory school nurse to student ratio?, Are students provided with healthy food service options?

In some cases, there may be a significant gap between official policies and programs and actual practice at your school. It may be useful to consult with school nurses, teachers and administrators to find out the extent to which the school is implementing district policies and programs and how effective they perceive these policies and programs to be in actually improving student health.

If you are interested in improving the quality of health programs in schools, it is valuable to conduct an assessment of existing services. Ask questions such as: What health services are provided at or near the school site?, What provisions exist for referring students to health services?, How easily can students reach the services to which they are referred? How many hours of classroom instruction in the area of health is provided at each grade level? Ideas for filling gaps and integrating the school-based health center into existing activities will come from this kind of assessment and accumulated data will help reinforce your argument that a center is needed.

- **The politics of your school or district, including who is influential and who is likely to help (or hinder!) your project**

The last, but by no means least, step in the pre-planning process is to become a student of school politics. It is important to learn how to generate political support for the establishment and maintenance of a school-based health center. A good first step is to ask "someone who knows." Approach a trusted friend, colleague or board member who can connect you with a school insider who will be willing to provide you with candid information. Ask about various school board factions (including their different positions on health issues) and the relationship between the board and the superintendent. Seek advice on how to approach individual board members or the board as a whole. Also, ascertain who should introduce issues to various board members and who should make policy recommendations. Similarly, learn who influences the superintendent. Identify who in the central office and in the school has power and influence over school policies and programs generally and school health specifically. Also find out which principals and/or vice principals and other district staff are particularly respected. Ask which unions and associations represent teachers, paraprofessionals and other school-related personnel (such as school nurses) and if they have taken a stand on school health issues.

You will need to know who is in charge of school operations, who is in charge of teacher training, who is in charge of student services, how much leverage parent organizations, unions, or other key bodies have in determining program direction, and whether or not the establishment of a school-based health center is a decision that is left to an individual school.

✓ List of Reasons to Become Involved in School-Based Health Care

Many Children Lack Access to Care
Many children lack health insurance and have little or no real access to health care. Schools have the social penetration to reach at-risk children and those who have fallen between the cracks in the health care system.

Bridging the Gap
Even children who receive adequate prenatal and/or perinatal care are at risk of not receiving necessary preventive health attention and health education during their elementary school years. Reaching kids in school can help bridge the gap between infancy and adolescence; childhood is a time when many health decisions are made with regard to nutrition, exercise, sexuality and drug use later.

Prevention
The school is an ideal environment in which to foster a preventive approach to children's health. Health education curricula can be reinforced by class work, cafeteria experiences, field trips, the school nurse and health center services. Health screenings, referral, services and parent involvement are all feasible elements of a school-based health center. And, as with all things concerning children, starting early and reinforcing messages in daily life is vital to promoting good health choices later.

Financing
With the increasingly wide acceptance of managed care, many health providers are moving toward large capitated provision systems. Managed care plans may result in substantially less funds potentially available to school health centers. At the same time, the trend toward school-based health care has been a rapidly escalating one. Currently, community and migrant health programs (and other health provider sponsors) have a window of opportunity to tap funding streams to support school-based health centers, supplementing what schools pay for health education, school nurses, special education services, etc.

Cross-sector Collaboration
Discussions between health providers and educators have moved from "Are education and health connected?" to "How can the connections be addressed?" A child's health and his/her educational potential are inextricably linked. Increasingly, schools are seeing health and social problems emerge at school — problems that require partnerships between educators and health care providers if they are to be prevented and solved. Community and migrant health centers can make an important contribution by working collaboratively with schools to address health problems that affect educational outcomes.

It is important to inquire about current school district concerns and priorities to see if the school-based health center fits in well.

The benefits of a school-based health center may seem obvious, but the barriers are not always easy to see. It is very important to involve parents, teachers, other community leaders, media, school board members, politicians, school administrators, religious leaders, and a host of other people concerned with the educational achievement and health status of children in the process. Anticipate who in the community is likely to be supportive of the center and who might oppose the proposal and even question your motives and actions. In most communities, there is strong parental support for some kind of health program in schools. There may, however, be a smaller but more vocal group who oppose important elements of school services and education.

Seek Feedback

Before making a formal proposal that the school work with your organization to start planning the establishment of a school-based health center be sure to seek feedback on your proposal's viability from friendly school officials, teachers, parent organization activists, or others connected with the school system. Do not forget to spend time learning from those who have already successfully partnered with their school to establish a center (a list of community health centers currently working at the elementary level is provided in Appendix A). Discuss who might be most receptive to your ideas. Be prepared to discuss what you are able to do for the students and school with some specificity. In most instances, one or more of your contacts will be able to tell you what the likely reaction will be to establishing a school health center, how to strengthen your proposal, how you might best state your case, whom you should contact first, and how to best proceed.

Of equal importance, be sure to identify and address the concerns of those who might be *opposed* to your efforts. If possible, include a

Think About the Future

The short-term goal is keeping kids in school. But our long-term goal is improving kids' health in the elementary years and beyond. You have to take the long-term view and be patient.

—Michael Discavage
Southern Lancaster Health Services

As you consider starting a school-based or -linked health center, consider as well how you will ensure its sustainability. Discussions with those who currently operate centers reveal that it is unlikely that original funding will continue in full force for more than a few years. The center must have a broad base of support (both financial and organizational) and center planners/managers must think about the demands of ongoing support even as they are working to start up the center. Once the center is operational, students and educators will begin to build trust in the staff and may come to expect the center to be there for them — a short-lived center may be as frustrating to the clients as it will be to its planners. An advantage of longevity is that parents may work to ensure that similar services are available at all school grades once they see that the center is a success and experience the benefits of the center for their children.

skeptic or opponent on the project planning committee — if such personal involvement would derail the process of planning for a school-based health center, be vigilant at least to actively include the viewpoints of opponents. Once a planning team has a sense of who may oppose school health and why it is possible to weigh options. For example, in the face of objections to a specific kind of service the planning team may opt to exclude provision of certain services initially and — after establishing the center's worth to the school and community — explore whether or not there is broad-based support for additional services.

If you are interested in changing school policies and procedures or influencing existing school health programs, you may need higher level authorization from the superintendent or other authorized official. In other words, in addition to obtaining approval (or authorization) to establish a center, you may need to obtain changes in policies and procedures (or waivers) as needed to permit the center to actually offer certain services. To obtain permission to operate a school-based health center you should outline what you hope to accomplish in a letter and request school or district cooperation. If change in policies or waivers are required, you will be well advised to obtain political support *prior* to proceeding through the legislative system's bureaucratic channels.

Design Activities Collaboratively

Once the principal, board or district has given approval for the general proposal to create a school-based health center, it will be necessary to develop a specific plan. It is imperative that you develop this plan in collaboration with whomever at the school would work with the center or oversee its activities. In some cases, you will need to work with multiple parties both inside and outside the school system. Keep in mind the importance of involving all key players in the planning process.

The best way to ensure that a school-based health initiative is planned collaboratively is to build a representative planning committee to oversee development of the project. Such a committee should include administrators, teachers, parents, health care providers, and decision makers or respected opinion leaders in the community. Strive to include a variety of sectors, from religion to politics, from community-based organizations to neighborhood leaders, from businesses to non-profits. After the school-based health center is up and running, this important planning team can become the center's ongoing oversight and advisory group. Establishing a planning and advisory team helps guarantee that the center will remain grounded in the community's needs and will provide a method for maintaining quality assurance.

Come to the planning table with specific ideas about what the health center will and will not do, and how many children it can serve, but be as flexible as possible to allow the best possible match with the school's needs and level of interest and comfort. If you require school resources to create the center (for example, space in the school site) it is critical to be clear about this from the beginning. Most school districts are in financial crisis and have limited ability to fund new initiatives or support personnel. Similarly, make sure to discuss what resources your organization brings to the school and what additional support you may be able to obtain from others in the community.

After reaching agreement on the design of the center and a time table for establishing it, put the plan in writing so that mutual objectives and obligations are clear to all. Arrange in advance for periodic meetings with appropriate parties to review progress and discuss how you can be more effective in starting the center (including what assistance the central office, principal or project supervisor can give to enhance the project). Place a premium on establishing realistic goals and measures for outcomes. It will be essential to justify the school-based health cen-

Focus on Financing

The ability to finance a program is essential—you can't run without it. We had a state grant to start up, but we cannot survive in the future without alternative sources to sustain services. Managed care is a major potential source of funds, but it's hard to set up workable arrangements and still equitably serve all children.

—Carol J. Martin
Community Health Care, Inc

This is always the big question for new school-based initiatives. School-based health centers vary enormously in cost, from hundreds of thousands of dollars to tens of thousands (but none are free).[27] Support will need to cover costs like staff, computer equipment, promotional materials, program evaluation, phone, copying, medications, etc. Where will you get the money? How is health care financing reform going to affect the center? Sources of funds for school-based health centers range across EPSDT services, MediGrant programming, state Medicaid managed care initiatives, private managed care and indemnity insurance plans, Maternal and Child Health funding, and philanthropic funding. Financing is a persistent issue for school-based health centers.

ter's continued existence by illustrating how the center's plan has met its objectives and carried out its obligations over time. This is a task well suited to the center's advisory team.

Generate Broad Support

Remember that state policies and programs are tremendous prods to districts to initiate and sustain activity. Successful local efforts may require a state strategy or support. Specifically, it may be helpful to work towards the following:

- enacting a state policy regarding school-based health centers in at-risk communities;
- establishing state policies supporting comprehensive services for children, youth and families delivered in an interagency, interdisciplinary collaborative manner;
- obtaining appropriations for school-based health services;
- developing accountability systems that provide information on the extent to which students have access to health services and demonstrate healthy behavior;
- examining state certification and licensure requirements from the perspective of preparing professionals to be cognizant of the importance of student health and the role of health in education; and
- increasing state education agency, state health department and other state agency capability to help local districts to plan for and implement effective school health programs.

Conclusion

As the preceding sections reflect, the educational system is a complex one and, for a variety of reasons, foreign to many health professionals. It is a separate arm of government with its own funding streams, electoral process, specialized professionals and a unique political tradition. Yet, at the federal, state and local levels, educators are increasingly poised to work with health professionals to address a vital missing link in the provision of comprehensive, continuous quality care to children: elementary school-based health centers. It is important that educators understand the need for such centers and that they clearly comprehend what health centers do — and do *not* do — for students.[28] Likewise, health professionals, especially community health care providers, should understand how to work with schools to foster health care services for disadvantaged students.

The school-based health center is not the only model for a community and not all communities or schools will need to create such an entity. But, school-based health centers are often very effective and hold unique promise as a model to assist at-risk children and their families. In addition, the health center model is proliferating rapidly, growing in popularity among leaders in the public and private sectors and gaining visibility with and support from parents, the health community and the education community.

While schools have not traditionally seen health as a priority area of activity, interest in the potential of school-based health initiatives in general (and school-based health centers in particular) has grown as the health needs of children and youth have become more complex and pressing. While schools have a long history of supporting such health professionals as school nurses, most educators and educational administrators do not understand the health community well and have a natural wariness of establishing a complex partnership with another child- serving sector. It is easy to see why: starting a school-based health center requires that a school assume responsibility for letting outside organizations share school space, assume some health responsibilities previously handled by school staff, introduce new staff to the school that is not under supervision of school personnel, and add another area of concern to the school's already full agenda.

It is up to health professionals to help make the connection between health status and educational achievement clear to educators. Likewise, community-based health providers will be called upon to document the potential of school-based health centers. Health advocates will need to help schools build support for school health centers and understand center funding and staffing over time. Such a challenge requires that health professionals have a working understanding of the educational setting and the needs and concerns of teachers and administrators. Ultimately, those who want to help address today's growing student health needs by tapping the school's unique status in the community must be able to simultaneously protect it as well — a task that will demand understanding of and respect for the education community and its mission.

If the health and education sectors will work together across traditional boundaries to establish interdisciplinary partnerships such as school-based health centers, many of the troubling health problems of today's students may be addressed. If such collaboration takes place during the elementary years, these illnesses may in fact be prevented — eliminating the need for costly and stigmatizing services later on. What's more, students may also learn to make healthier behavior choices, eating right, exercising, making safe, thoughtful and respectful choices about their emerging sexuality, and forgoing alcohol or drug abuse for a healthier, happier, more productive lifetime.

THE NATIONAL ASSEMBLY ON SCHOOL-BASED HEALTH CARE

During a national conference, "Breaking New Ground," held from June 23-25, 1995 some 500 individuals and organizations representing all aspects of school-based health convened in Washington, DC to create a new national association: the National Assembly on School-Based Health Care.

The National Assembly was formed to promote and assure quality primary health care to the nation's children and youth. The Assembly believes school-based health centers represent an essential strategy toward improving the lives of young citizens and optimizing their ability to become contributing members of society. The Assembly is committed to the notion that while increasing access to physical and mental health services, school-based health centers offer compassionate and competent care which addresses the unique needs of children and youth.

The new Assembly also serves as a membership organization and collegial home for the growing number of interdisciplinary professionals dedicated to the concept of implementation of school-based health centers. Through a variety of activities which include advocacy, information exchange, and technical assistance, the Assembly provides a centralized locus committed to the advancement of school-based health care.

The Assembly's goals are:

- to expand the number of school-based health centers
- to build a membership organization which has an important role nationally
- to help institutionalize school-based health centers
- to promote evaluation of school-based health care
- to promote parental/community involvement in school-based health care
- to address interdisciplinary staffing concerns
- to coordinate information exchange and provide technical assistance
- to facilitate a national network among school-based health organizations
- to support development of partnerships for school-based health initiatives

The National Assembly is overseen by an executive council (with advocacy, communications, finance and program committees) and has a number of special sections (akin to the structure of the American Public Health Association's membership sections) including the following: program administration; research and evaluation; psycho-social services; health education services; integrated services, interdisciplinary training and evaluation; and health services delivery.

For additional information on the Assembly or for a membership application, please contact the National Assembly on School-Based Health Care, 6728 Old McLean Village Drive, McLean VA 22101, (703) 556-0411.

Appendix A

Community and Migrant Health Centers Implementing Elementary School Health Services

This report has been designed to provide the reader with valuable information on how the school operates, who runs it, and how the education sector is structured at the local, state and federal levels. Such information is essential to those who seek to partner with schools to establish school-based health centers. However, often it is as helpful to speak directly with individuals who have successfully brokered a relationship with schools and who are operating SBHCs on a day-to-day basis. For this reason, NHEC has included the list of contact names below.

The individuals and programs listed below represent school-based health center initiatives operated by community and migrant health centers in elementary schools. This list of select organizations was made by the National Association of Community Health Centers' Adolescent and School Health Initiative from among health centers responding to a survey on school health services. Feel free to contact an appropriate name in your state or public health region.

In addition, both the National Association of Community Health Centers (NACHC) and the National Health & Education Consortium (NHEC) will be pleased to help network you with individuals who may be helpful in your planning efforts. Likewise, the new National Assembly on School-Based Health Care (see page 24) has established a broad network of technical assistance providers in the area of elementary and adolescent school-based health center issues that will be of use to you.

Alabama
Whatley Health Services, Inc.
2731 Martin L. King, Jr. Boulevard
Tuscaloosa, AL 35401
(ph) 205/349-3250
(fx) 205/345-3993
contact: Marilyn Archibald

Arizona
Clinica Adelante
16560 North Dysart Road
Surprise, AZ 85374
(ph) 602/546-2194
(fx) 602/546-2310
contact: Nancy Hook

California
La Clinica de la Raza
151 Fruitvale Avenue
Oakland, CA 94601
(ph) 510/535-4000
(fx) 510/535-4189
contact: Jodee Kazemimi-Wallace

Logan Heights Family Health Center
1809 National Avenue
San Diego, CA 92113
(ph) 619/234-8171
(fx) 619/237-1856
contact: Fran Butler-Cohen

North County Health Services
629 Second Street
Encinitas, CA 92024
(ph) 619/753-7842
(fx) 619/757-3004
contact: Steven Nakamura

Colorado
Valley-Wide Health Services, Inc.
204 Carson Avenue
Alamosa, CO 81101
(ph) 719/589-5161
(fx) 719/589-5722
contact: Christine Hettinger-Hunt

Connecticut
Community Health Center, Inc.
635 Main Street
Middletown, CT 06457
(ph) 203/347-6971
(fx) 203/347-2043
contact: Jesse White-Frese

Hawaii
Kalihi-Palama Health Center
915 N King Street
Honolulu, HI 96817
(ph) 808/845-8578
(fx) 808/841-1265
contact: Chuck Duart

Massachusetts
Lynn Community Health Center
269 Union Street
P.O. Box 526
Lynn, MA 01901-1314
(ph) 617/581-3900
(fx) 617/598-1050
contact: Bob Dempkowski

Michigan
Cherry Street Services, Inc.
550 Cherry Street, SE
Grand Rapids, MI 49503
(ph) 616/235-9798
(fx) 616/235-0739
contact: Donna Vesey

Mississippi
Northeast Mississippi
Health Care, Inc.
12 E. Brunswick Avenue
P.O. Box 698
Byhalia, MS 38611-0698
(ph) 601/838-2163
(fx) 601/838-7944
contact: Teresa Crockett

Missouri
Samuel U. Rodgers Community
Health Center, Inc.
825 Euclid
Kansas City, MO 64124
(ph) 816/889-4604
(fx) 816/474-6475
contact: Cheryl Fleming

New Jersey
Community Health Care, Inc.
105 Manheim Avenue
Bridgeton, NJ 08302
(ph) 609/451-4700
(fx) 609/451-0029
contact: Patti Leigh

New York
East Harlem Council for Human
Services-SHP
2253 Third Avenue, 3rd Floor
New York, NY 10035
(ph) 212/650-4906
(fx) 212/360-6149
contact: M. Pamala Miller

Family Health Network of Central
New York
35 Main Street
Cortland, NY 13045
(ph) 607/753-3797
(fx) 607/753-6677
contact: Susan M. Ulrich

Geneva B. Scruggs Community
Health Care Center, Inc.
567 Kensington Avenue
Buffalo, NY 14214
(ph) 716/894-3556
(fx) 716/894-3203
contact: Isabel McMahon

Montifore Ambulatory Care
Network
3544 Jerome Avenue
Bronx, NY 10467
(ph) 718/920-6062
(fx) 718/515-7741
contact: Dr. David Appel

NENA Comprehensive Health
Center
279 East Third Street
New York, NY 10009
(ph) 212/477-8500
(fx) 212/473-4970
contact: Elizabeth Gunhus

Sunset Park Family Health Center
150-55th Street
Brooklyn, NY 11220
(ph) 718/630-7216
(fx) 718/492-5090
contact: Jim Stiles, or Orianne Shrir

Oklahoma
Konawa Community Health
Improvement Association, Inc.
527 West Third Street
P.O. Box 358
Konawa, OK 74849
(ph) 405/925-3266
(fx) 405/925-2362
contact: Howard Vincent

Rhode Island
Westbay Community Action, Inc.
3308 Post Road
Warwick, RI 02886
(ph) 401/737-2050
(fx) not available
contact: Nancy T. Heroux

Pennsylvania
Southern Lancaster Health Services
630 Rockland Street, Box 598
Lancaster, PA 17602
(ph) 717-299-6371
(fx) 717/397-8881
contact: Michael Discavage

Tennessee
Memphis Health Center
360 EH Crump Boulevard
Memphis, TN 38126
(ph) 901/775-2000
(fx) 901/775-2938
contact: Renee Ware

West Virginia
E.A. Hawse Health Center
P.O. Box 97
Baker, WV 26801
(ph) 304/897-5915
(fx) 304/897-5917
contact: Joyce M. Teets

New River Family Health Center
Box 337
Scarboro, WV 25917
(ph) 304/469-2905
(fx) 304/465-5486
contact: Jenifer Mead

APPENDIX B

Healthy People 2000 and the National Education Goals

Two major federal initiatives have shaped the context within which health and education collaboration take place. The first is the release of the historic *Healthy People 2000: National Health Promotion and Disease Prevention Objectives* in 1990. The report, and a related conference of national organizations, stemmed from a 1979 health strategy put forward by the Surgeon General in *Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention* and expands upon the 1980 initiative, *Promoting Health/Preventing Disease: Objectives for the Nation*, which set out a health agenda to the year 1990. *Healthy People 2000* contains the now famous vision for U.S. health in the 21st Century, and its attendant health status objectives which detail specific bench marks. Couched in a governmental format, the objectives address pressing health care concerns designed to involve national, state and local organizations across the public and private sectors. For example, achieving "Priority 2, Objective 2.2: "Reverse the rise in cancer deaths to achieve a rate of no more than 130 per 100,000 people" would obviously make a real impact on the nation's well-being.

Healthy People 2000 sets out three laudable health goals for the nation: (1) healthy lives for more Americans, (2) elimination of disparities among population groups, and (3) access to necessary preventive services for everyone. The report then addresses the need for action on and sets out specific objectives for eight priority areas in preventive health: physical activity and fitness; nutrition; tobacco; alcohol and other drugs; family planning; mental health and mental disorders; violent and abusive behavior; and educational and community-based programs. How seriously the federal government will pursue these health goals as its guiding benchmark as we near the year 2000 remains to be seen.

In 1989, at the same time that the *Healthy People 2000* goals were being finalized, former President Bush convened the nation's governors to decide upon a set of overarching goals to guide educational reform in the United States. The governors, led by then Governor Bill Clinton, established six national education goals, the first ever created for the country. After achieving the presidency, Bill Clinton, like presidents before him, carried his prior interests into his administration, pushing to codify the national education goals (which became law in 1994) and requesting one of the largest increases for program spending in his FY96 budget for the Goals 2000 initiative.

In fact, the "Goals 2000: Educate America Act" (PL 103-227) established eight goals, two more than originally put forth by the governors at the 1989 Charlottesville, VA conference. Congress declared the National Education Goals to be the following:

(1) School Readiness — by the year 2000, all children in America will start school ready to learn;

(2) School Completion — by the year 2000, the high school graduation rate will increase to at least 90 percent;

(3) Student Achievement and Citizenship — by the year 2000, all students will leave grades 4, 8, and 12 having demonstrated competency over challenging subject matter including English, mathematics, science, foreign languages, civics and government, economics, arts, history, and geography, and every school in America will ensure that all students learn to use their minds well, so they may be prepared for responsible citizenship, further learning, and productive employment in our Nation's modern economy;

(4) Teacher Education and Professional Development — by the year 2000, the Nation's teaching force will have access to programs for the continued improvement of their professional skills and the opportunity to acquire the knowledge and skills needed to instruct and prepare all American students for the next century;

(5) Mathematics and Science — by the year 2000, United States students will be first in the world in mathematics and science achievement;

(6) Adult Literacy and Lifelong Learning — by the year 2000, every adult American will be literate and will possess the knowledge and skills necessary to compete in a global economy and exercise the rights and responsibilities of citizenship;

(7) Safe, Disciplined, and Alcohol- and Drug-free Schools — by the year 2000, every school in the United States will be free of drugs, violence, and the unauthorized presence of firearms and alcohol and will offer a disciplined environment conducive to learning; and

(8) Parental Participation — by the year 2000, every school will promote partnerships that will increase parental involvement and participation in promoting the social, emotional, and academic growth of children.

Although under heavy fire recently, Goals 2000 does not impose mandates on states and localities and has had bipartisan support through two administrations. Its fate will likely be decided during the 104th Congress.

A number of the *Healthy People 2000* objectives and the *National Education Goals* are related directly — and indirectly — to school health programs. According to the U.S. Department of Health and Human Services:

> Approximately one third of the 300 national health promotion and disease prevention objectives in *Healthy People 2000* can be attained either directly or indirectly through schools and school-based programs. These health objectives are complemented by "GOALS 2000: Educate America," the strategy laid out by the Clinton Administration for achieving the National Education Goals by the year 2000.[29]

For example, under the National Education Goal of school readiness, the Clinton Administration has set a National Education Objective calling for "all disadvantaged and disabled children [to have] access to high quality and developmentally appropriate preschool programs that help prepare children for school."[30] A related national health promotion and disease prevention objective can be found in objective 8.3, "achieve for all disadvantaged children with disabilities access to high quality and developmentally appropriate preschool programs that help prepare children for school, thereby improving their prospects with regard to school performance, problem behaviors, and mental and physical health."[31]

To obtain additional and more complete information on how the *Healthy People 2000* objectives and National Education Goals relate to one another around the issue of school-based health, see *School Health: Findings from Evaluated School Health Programs*, a publication of the U.S. Department of Health and Human Services.[32]

Joint Statement on School Health By the Secretaries of Education and Health and Human Services

Health and education are joined in fundamental ways with each other and with the destinies of the Nation's children. Because of our national leadership responsibilities for education and health, we have initiated unprecedented cooperative efforts between our Departments. In support of comprehensive school health programs, we affirm the following:

- *America's children face many compelling educational and health and developmental challenges that affect their lives and their futures.*

  These challenges include poor levels of achievement; unacceptably high drop-out rates; low literacy; violence; drug abuse; preventable injuries; physical and mental illness; developmental disabilities; and sexual activity resulting in sexually transmitted diseases, including HIV, and unintended pregnancy. These facts demand a reassessment of the contributions of education and health programs in safeguarding our children's present lives and preparing them for productive, responsible, and fulfilling futures.

- *To help children meet these challenges, education and health must be linked in partnership.*

  Schools are the only public institutions that touch nearly every young person in this country. Schools have a unique opportunity to affect the lives of children and their families, but they cannot address all of our children's needs alone. Health, education, and human service programs must be integrated, and schools must have the support of public and private health care providers, communities and families.

- *School health programs support the education process, integrate services for disadvantaged and disabled children, and improve children's health prospects.*

  Through school health programs, children and their families can develop the knowledge, attitudes, beliefs, and behaviors necessary to remain healthy and perform well in school. These learning environments enhance safety, nutrition, and disease prevention; encourage exercise and fitness; support healthy physical, mental, and emotional development; promote abstinence and prevent sexual behaviors that result in HIV infection, other sexually transmitted diseases, and unintended pregnancy; discourage use of illegal drugs, alcohol, and tobacco; and help young people develop problem-solving and decision-making skills.

- *Reforms in health care and in education offer opportunities to forge partnerships needed for our children in the 1990s.*

  The benefits of integrated health and education services can be achieved by working together to create a "seamless" network of services, both through the school setting and through linkages with other community resources.

- Goals 2000 *and* Healthy People 2000 *provide complementary visions that, together, can support our joint efforts in pursuit of a healthier, better educated Nation for the next century.*

  Goals 2000 challenges us to ensure that all children arrive at school ready to learn; to increase the high school graduation rate; to achieve basic subject matter competencies; to achieve universal adult literacy; and to ensure that school environments are safe, disciplined, and drug free. *Healthy People 2000* challenges us to increase the span of healthy life for the American people, to reduce and finally to eliminate health disparities among population groups, and to ensure access to services for all Americans.

In support of *Goals 2000* and *Healthy People 2000*, we have established the Interagency Committee on School Health co-chaired by the Assistant Secretary for Elementary and Secondary Education and the Assistant Secretary for Health, and we have convened the National Coordinating Committee on School Health to bring together representatives of major national education and health organizations to work with us.

We call upon professionals in the fields of education and health and concerned citizens across the Nation to join with us in a renewed effort and a reaffirmation of our mutual responsibility to our Nation's children.

Richard W. Riley
Secretary of Education

Donna E. Shalala
Secretary of Health and Human Services

NHEC OVERVIEW

The health and education of children are intricately linked. Yet, for a variety of historical and societal reasons, these two critical facets of children's development have been separated. As a result, society finds itself either concerned about the "health" of children or the "education" of children, but is all-too-rarely aware of how the two fields are interdependent.

In 1990, in recognition of the need for better integration of health and education programs for children in this country, the National Health & Education Consortium was established by the National Commission to Prevent Infant Mortality (NCPIM) and the Institute for Educational Leadership (IEL) with core financial support from the Prudential Foundation. As a result of this special partnership, NHEC, from its inception, was a public/private partnership grounded in both the education and health communities.

NHEC now brings together 58 national health and education professional member associations, representing some 12 million constituents, to design strategies to better coordinate health and education services and programs. It does not represent any particular special interest group, but uniquely can mobilize the collective influence of national membership associations on behalf of its mission.

The National Health & Education Consortium contends that children must be healthy to be able to learn, and that they must be educated to keep themselves healthy for a lifetime. Millions of infants and children lack access to health care or suffer from poor health, leaving them vulnerable to physical and learning problems. And, far too often, information on how to maintain a healthy lifestyle does not reach those in greatest need. Coordination of health and education services for children can enhance their ability to learn, succeed in school and become productive members of society.

NHEC Agenda for Action

- to improve public policy by addressing the need for a better coordinated health and education delivery system;
- to strengthen communication and dissemination of information between health and education practitioners and policymakers; and,
- to identify exemplary program models and practices which more effectively integrate health and education services.

To accomplish its mission, NHEC produces occasional papers, special reports and major research documents focused on various topics relating to collaboration between the health and education communities. NHEC also provides training and technical assistance to federal, state and local leaders to promote collaborative efforts at all levels of government and in the private sector, and operates a number of special programs.

National Health & Education Consortium Members

American Academy of Family Physicians: represents 71,000 physicians

American Academy of Pediatrics: represents 45,000 pediatricians

American Association of Colleges for Teacher Education: represents 706 Member Institutions' teacher education programs

American Association of School Administrators: represents 18,517 school administrators

American College of Nurse-Midwives: represents 3,500 practicing nurse-midwives

American College of Obstetricians and Gynecologists: represents 31,000 obstetricians and gynecologists

American Dental Association: represents 140,000 dentists

American Federation of Teachers: represents 750,000 teachers, para-professionals (teacher aides), school-related personnel, health-care workers, federal and state employees

American Hospital Association: represents 5,870 hospitals and over 50,000 physicians

American Indian Health Care Association: represents 36 programs and clinics which focus on the health care of American Indians

American Medical Association: represents 300,000 physicians

American Nurses Association: represents 201,000 registered nurses

American Psychological Association: represents 118,000 clinicians, researchers, educators, consultants and students

American Public Health Association: represents 30,977 physicians, nurses, therapists, health technicians, health support personnel, and other health professionals

American School Food Service Association: represents 65,000 child nutrition and school food service employees

American School Health Association: represents 4,100 health educators, nurses, physicians and dieticians

American Speech-Language-Hearing Association: represents 74,000 audiologists and speech-language pathologists

Association for the Care of Children's Health: represents 4,200 nurses, Child Life workers, and parent leaders

Association for Supervision and Curriculum Development: represents 153,000 teachers, school administrators, college professors and school board members

Association of American Medical Colleges: represents 126 U.S. medical schools, 450 teaching hospitals, and 94 academic professional societies

Association of Maternal and Child Health Programs: represents 269 Maternal and Child Health Program directors and staff

Association of Schools of Public Health: represents 14,500 faculty and students at 26 certified schools of public health

Association of State and Territorial Dental Directors: represents 44 state dental directors nationwide

Association of State and Territorial Health Officials: represents 58 health officers from each of the United States and its territories

Association of Women's Health, Obstetric and Neonatal Nurses: represents 24,700 nurses

Council of Chief State School Officers: represents 56 public officials who head departments of elementary and secondary education in each state and extrastate jurisdiction

Council of the Great City Schools: represents 47 of the largest urban public school districts in the United States

Healthy Mothers, Healthy Babies Coalition: represents 95 non-profit health education groups, and state and local education groups

National Alliance of Black School Educators: represents 4,000 African-American teachers for grades K-12

National Association for Asian & Pacific American Education: represents approximately 500 educators concerned for the educational well-being of Asian and Pacific American students

National Association for the Education of Young Children: represents nearly 77,000 professionals and others who study or are interested in childhood education and development

National Association of Children's Hospitals and Related Institutions: represents 108 hospitals

National Association of Community Health Centers: represents 800 community, migrant and homeless primary health care centers serving over 8 million patients in medically underserved areas. Centers employ or contract with over 4,000 primary care physicians and 7,250 nurses and mid-level practitioners

National Association of Elementary School Principals: represents 26,000 elementary and middle school principals in the United States, Canada and overseas

National Association of Hispanic Nurses: represents 1,000 Hispanic nurses

National Association of Partners in Education: represents 5,500 volunteers, presidents and executives of private businesses, teachers and administrators

National Association of Pediatric Nurse Associates and Practitioners: represents 4,200 pediatric nurse associates and practitioners

National Association of School Nurses, Inc.: represents 8,000 school nurses

National Association of Secondary School Principals: represents 41,000 secondary school principals, administrators, guidance counselors, activities directors and college professors

National Association of Social Workers, Inc.: represents 145,000 professionals and para-professionals in the field of social work

National Association of State Boards of Education: represents 600 state boards of education and their members

National Association of State School Nurse Consultants: represents over 20,000 school nurses in 12,000 school districts with responsibility for comprehensive school health services programs

National Association of WIC Directors: represents 624 state directors, nutrition coordinators, and local agency directors

National Black Nurses' Association: represents 7,000 African-American nurses

National Coalition of Hispanic Health and Human Services Organizations (COSSMHO): represents 12,000 organizations serving the Hispanic population, representing Hispanic physicians, nurses and students

National Community Education Association: represents 1,550 teachers, superintendents, administrators, community education directors and coordinators, faculty and administrators of teacher education institutions and programs, community activists, private businesses and state administrators

National Education Association: represents 2 .1 million K-12 classroom teachers, professors, educational support personnel and students

National Head Start Association: represents 5,000 professionals working with Head Start programs nationwide

National Indian Education Association: represents 2,700 individuals dedicated to promoting quality education for American Indian and Alaskan Native people

National Medical Association: represents 16,500 primarily African-American minority physicians

National Mental Health Association: represents 450 local affiliate mental health associations, comprised of mental health care providers and clients, and community mental health centers

National Perinatal Association: represents 2,500 physicians, nurses, nurse-midwives, social workers and consumers of perinatal services

National PTA (National Congress of Parents and Teachers): represents 6.8 million parents, K-12 classroom teachers, principals, school administrators and students

National Rural Health Association: represents 2,000 community, migrant and homeless health centers and their staffs

National School Boards Association: represents 52 state school board associations

National School Public Relations Association: represents 2,200 teachers, principals, administrators, retired teachers, students and public relations personnel

Society for Neuroscience: represents 21,219 neuroscientists

Zero to Three/National Center for Clinical Infant Programs: Represents 7,500 programs for high risk children and families, as well as individuals

National Association of Community Health Centers

Community and Migrant Health Centers are public or private, non-profit community-based health care organizations which provide comprehensive preventive and primary health care services in medically underserved communities and to medically underserved populations. Supported in part through federal grants from the U.S. Department of Health and Human Services, Public Health Service, Bureau of Primary Health Care, approximately 800 health centers serve approximately 8 million patients nationally. Located in inner cities, small towns and rural communities, health centers provide access to primary health care on a sliding fee scale based on ability to pay. A significant proportion of health center patients have incomes at or below the federal poverty level, approximately half of them are uninsured, and a majority of those with insurance have Medicaid or Medicare coverage. Health centers are dedicated to improving access to primary health care services for medically underserved communities and populations.

The National Association of Community Health Centers (NACHC) has been awarded a cooperative agreement from the Centers for Disease Control and Prevention to establish and implement NACHC's Adolescent and School Health Initiative. The primary goal of the initiative is to significantly enhance the capacity of Federally Qualified Health Centers to expand and improve preventive and primary health programs targeted to youth at high risk for HIV/AIDS, sexually transmitted diseases, and other health problems through developing school-based or school-linked comprehensive services in cooperation with schools in their communities.

NACHC's Adolescent and School Health Initiative offers:

- a **resource center** on adolescent health promotion and problem prevention, including HIV/STD prevention; and school health programs for children and youth;
- **training needs assessments** for development of training curriculum;
- **local, state-based and regional training sessions and technical assistance** on how to establish and strengthen School-Based and School-Linked Health Programs and HIV/AIDS prevention programs for children and adolescents;
- **information** and **consultation** from a trained health educator; supplemented by coordinated use of resources from other national organizations involved in school health;
- **development of a database** on health center school-based and -linked health programs;
- **showcasing of effective health center school-based and -linked programs** for children and youth;
- **information on policy and program developments** provided through the NACHC newsletters, issue briefs and conference educational sessions.

Utilize the resource center.
Participate in the campaign to improve our youth's health.

Call or write NACHC's Adolescent and School Health Initiative, Attention: Darryl Burnett, MPH, CHES, Project Manager, 1330 New Hampshire Avenue, N.W., Washington, D.C. 20036, (202) 659-8008, extension 131, facsimile (202) 659-8519.

Endnotes

1. *The Answer Is At School: Bringing Health Care To Our Students.* Washington, D.C.: The School-Based Adolescent Health Care Program, 1993. P.8.

2. Definitions are taken from a June, 1994 working meeting convened by Advocates for Youth in Washington, DC and reflect work conducted by Joy Dryfoos and the Advocates for Youth staff as well as comments from meeting participants.

3. *A Directory of Community and Migrant Health Centers Implementing Health Services in Cooperation With Schools.* Washington, DC: National Association of Community Health Centers, 1995. Pre-publication copy.

4. Guthrie, Grace Pung and Larry F. Guthrie. "Streamlining Interagency Collaboration for Youth at Risk." *Educational Leadership*, September 1991. P.17.

5. Much of this section is taken from "History of School-Based Services and School-Based Clinics" in *School-Based Health Clinics: A Guide To Implementing Programs.* Advocates for Youth. Washington, DC: 1986. Pp. 8-9.

6. Making the Grade can be reached at (202) 466-3396, or by writing Dr. Julia Graham Lear, Making the Grade, The George Washington University, 1350 Connecticut Avenue, NW, Suite 505, Washington, DC 20036.

7. McKinney, Debra Hauser and Geri Lynn Peak. *School Based and School-Linked Health Centers.* Advocates for Youth. Washington, DC: 1994. P. 1.

8. *National Survey Results on Drug Use from The Monitoring The Future Study: 1975-1992. Vol I.* Rockville, MD: U.S. Department of Health and Human Services, 1992. P.133.

9. Ibid., P. 37.

10. *Community Childhood Hunger Identification Project — A Survey of Childhood Hunger in the United States.* Washington, D.C.: Food Research and Action Center, 1995.

11. *AIDS and School Health Education: State Policies and Programs.* Washington, DC: Council of Chief State School Officers, 1990.

12. Ibid.

13. *Putting Learning First: Governing and Managing the Schools for High Achievement (A Statement by the Research and Policy Committee of the Committee for Economic Development).* New York: Committee for Economic Development, 1994. Pp. 4-5.

14. Both this section and the section on "How to Work With Schools" are taken in large part from *Bridging the Gap: An Education Primer for Health Professionals* (prepared by Candace Sullivan and based on the National Association of State Boards of Education publication *How Schools Work and How To Work with Schools*, co-authored by Janice Earle, William Kane and Candace Sullivan) in *Bridging the Gap: A Health Care Primer for Education Professionals/An Education Primer for Health Professionals.* Holschneider, S. et al. Washington, DC: National Health & Education Consortium, 1992.

15. "The Relationship Between School Boards and General Purpose Government." Usdan, Michael. *Phi Delta Kappan*, January 1994. Pp. 371-377.

16. Ibid.

17. The exact number for the 1993-4 school year was 14,881 school districts. *1995 Digest of Educational Statistics.* Washington, DC: U.S. Department of Education, 1995.

18. Ramon Cortines, the recent former Chancellor of New York City's public school system, was faced throughout his tenure with a series of now famous squabbles with Mayor Rudolph Giuliani over issues like school safety, central office staffing and the school system budget. Mayor Giuliani, not unlike some other big city mayors, has been engaged in a bid to secularize the education sector and obtain more direct control over public education policy and financing. The level of opposition he faced from the mayor helped push Chancellor Cortines to resign in October, 1995.

19. In 1991, 97.1% of school board members were elected according to the National School Boards Association, and the number appears to be on the rise. Data taken from *Characteristics of Local School Boards and Selection Methods and Taxing Authority.* Richmond, VA: Virginia State Legislature, for the Virginia School Boards Association, 1991.

20. Recent data from the Council of Great City Schools indicates that the average term for big city superintendents is a mere 2.5 years. Conversation with Henry Duvall, Director of Communications, Council of Great City Schools, 1995.

21. The ten largest major categorical federal programs affecting children and families are the following: Aid to Families with Dependent Children (AFDC); Chapter One (also known as Title One of the Elementary and Secondary Education Act); Earned Income Tax Credit; Food Stamps; Head Start; Job Training Partnership Act; Medicaid; National School Lunch Program; Section 8 Housing Assistance; and the Special Supplemental Food Program for Women, Infants and Children (WIC). Of these, 5 deal directly with schools and all affect at-risk children (and their families) who comprise the student body. Dunkle, Margaret. "Notes on Ten Major Federal Programs Affecting Children & Families: Draft prepared for senior congressional staff seminars." Washington, DC: Policy Exchange (Institute for Educational Leadership), 1992.

22. *The Status of the American Public School Teacher, 1990-1.* Washington, DC: National Education Association, 1991.

23. For more information about school nurses, refer to NHEC's Occasional Paper #9, "School Nursing: Trends for the Future." Passarelli, Carole. "School Nursing: Trends for the Future." Washington, DC: National Health & Education Consortium, 1993.

24. See Appendix B for a brief discussion and listing of the National Education Goals.

25. The seven states formally supporting the "Joint Statement" are: California, Maine, Nebraska, New Jersey, New York, North Carolina, and Vermont.

26. In 1992-3, the federal government provided 6.9% of all education dollars. *Digest of Education Statistics, 1995 Edition.* Washington, DC: U.S. Department of Education, 1995.

27. In 1993, Advocates for Youth (then called the Center for Population Options) conducted a survey of school-based health centers that reported widely varying budgets for SBHCs — from less than $5,000 per year to more than $670,000. The average annual budget was close to $170,000. (From *School-Based and School-Linked Health Centers, Update 1993.* Washington, DC: Advocates for Youth, 1994.)

28. For a fuller description of what school-based health centers are and how they are supported, staffed and operated please see the NHEC publication, *Starting Young: School-Based Health Centers at the Elementary Level*; the report was designed with the informational needs of educational administrators in mind and was produced in partnership with the National Association of Elementary School Principals.

29. *School Health: Findings From Evaluated School Health Programs.* Washington, DC: U.S. Department of Health and Human Services, Public Health Service, 1993. *School Health* may be ordered from the U.S. Government Printing Office by phone/fax with a VISA or Mastercard, or by prepaying with a check (invoices are accepted only for U.S. Government Agencies or college book stores). *Phone/Fax* — Call the automated phone ordering system at (202) 512-1800 or fax a request with your Mastercard or VISA number to (202) 512-2250. *Prepaid* — send a check to the U.S. Superintendent of Documents at PO Box 371954, Pittsburgh, PA 15250-7954. Each order, however placed, should include the stock number for *School Health*: #017-022-01232-4. Copies are $8.50 each.

30. Ibid.

31. Ibid.

32. Ibid.

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Selected References

Community Health Centers: Challenges in Transitioning to Prepaid Managed Care. Washington, DC: U.S. General Accounting Office, 1995.

Dollars & Sense: Diverse Perspectives on Block Grants and the Personal Responsibility Act. Dunkle, Margaret, Sam Halperin and Cheryl Hayes, Ed.s. Washington, DC: Institute for Educational Leadership and the Finance Project, 1995.

Full Service Schools — A Revolution in Health and Social Services for Children, Youth and Families. Dryfoos, Joy G. San Francisco: Jossey-Bass, Inc. Publishers, 1994.

Healthy People 2000: National Health Promotion and Disease Prevention Objectives. Washington, DC: U.S. Department of Health and Human Services, 1990.

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Together We Can: A Guide for Crafting a Profamily System of Education and Human Services. Blank, Martin, Tia Melaville and Gelareh Asayesh. Bruce Thompson, Ed. Washington, DC: U.S. Department of Education (Office of Educational Research and Improvement) and U.S. Department of Health and Human Services (Office of the Assistant Secretary for Planning and Evaluation), 1993.

National Association of Community Health Centers' Adolescent and School Health Initiative Publications List

In a survey of health centers in 1993/94, NACHC received 332 responses from health centers, and identified 123 centers providing some type of school health service; 62 (one-half of respondents) reported providing some services to elementary school children. Overall, 25 percent of health centers performed needs assessments to establish or maintain school-based or school-linked health centers, and 75 percent of centers were interested in initiating school health services.

The *Program and Training Needs Assessment on FQHC School-Based and School-Linked Services* provided information that is referenced in the following publications:

- **Program Summary Report: Health Centers' School Health Services**
  Addresses [1] finance/billing arrangements, [2] funding sources, [3] staffing, [4] services provided, and [5] significant contributions made by school health interventions.

- **An Assessment of Training Needs of Health Centers Involved in or Interested in Initiating School Health Services**
  Focuses on the training and technical assistance needs of more than 330 health centers in relation to school health services.

- **A Directory of Community and Migrant Health Centers Implementing Health Services in Cooperation With Schools**
  Includes information on how to reference each center for technical assistance and also provides information about [1] financial billing and managed care, [2] funding sources, [3] staffing, [4] services provided, [5] linkages with other programs, [6] the ranking of most significant contributions of the SBHC/SLHC, and [7] the ranking of the most significant health problems of youth.

The National Association of Community Health Centers, Inc. also provides numerous other publications that provide information and technical assistance for health centers. Please call the NACHC offices for additional information at (202) 659-8008.

Please indicate the number of publications requested in the spaces provided.

___ ***Hidden Casualties: The Relationship Between Violence and Learning*** (Special Report) — Deborah Prothrow-Stith and Sher Quaday of the Harvard School of Public Health take a developmental approach to exploring the impact of violence on a child's receptivity to education and ability to learn. (1995,$10)

___ ***The Invisible Disability: Understanding Learning Disabilities in the Context of Health and Education*** (Occasional Paper #11) — Dr Pasquale Accardo of Cardinal Glennon Children's Hospital of St. Louis examines the roles that the medical/health and education communities can and must play to enable children with learning disabilities to achieve to their maximum learning potential. (1995, $5)

___ ***The Big Red How To Guide: Planning a Health Fair for Children and Families*** (Training Material) — provides step-by-step guidance on planning and implementing a local health fair. (1995, $15)

___ ***Starting Young: School-Based Health Centers at the Elementary Level*** (Special Report) — provides historical and current info. on school-based health care with additional info. on staffing patterns, funding, and the value of preventive health care to elementary age children; produced in collaboration with the National Association of Elementary School Principals. (1995, $10)

___ ***Putting Children First: State-Level Collaboration Between Education and Health*** (Special Report) — describes interventions used in four pilot states (Florida, Maryland, New Mexico and Texas) to promote collaboration between the health and education sectors; provides suggestions to state leaders working to foster similar collaborative relationships. (1995, $10)

___ ***Fetal Alcohol Syndrome: The Impact on Children's Ability to Learn*** (Occasional Paper #10) — examines the root causes and consequences of Fetal Alcohol Syndrome and its impact on a child's ability to learn; describes some innovative programs and suggests recommendations for action; produced in collaboration with the Children of Alcoholics Foundation. (1994, $5)

___ ***Texas' Youth, Texas' Future*** (Special Report) —produced for NHEC by IEL's Center for Demographic Policy, identifies the demographic trends of Texas' children at health and educational risk and provides data to facilitate collaborative planning strategies for the education and health systems. (1993, $12)

___ ***Florida's Youth, Florida's Future*** (Special Report) — produced for NHEC by IEL's Center for Demographic Policy, identifies the demographic trends of Florida's children at health and educational risk and provides data to facilitate collaborative planning strategies for the education and health systems. (1993, $12)

___ ***School Nursing: Trends for the Future*** (Occasional Paper #9) — Carole Passarelli of the Yale School of Nursing highlights the increased need for school health nurses — providing recommendations for the best use of these essential professionals, illustrating various settings in which school nurses play an integral role, and describing current progressive school nurse programs. (1993, $5)

___ ***Eat to Learn, Learn to Eat: The Link Between Nutrition and Learning in Children*** (Special Report/Occasional Paper #7) — provides an overview of the link between nutrition and learning in children; describes the successes and limitations of public and private child nutrition programs; suggests action steps improve children's nutritional status; produced in collaboration with the American School Food Service Association. (1993, $10)

___ ***Children's Mental Health and Their Ability to Learn*** (Occasional Paper #8) — written by the National Mental Health Association, examines the current status of children's mental health and its impact on children's ability to learn; includes info. on services available to address needs and suggests policy and action steps to improve the provision, availability and accessibility of these services. (1993, $5)

___ ***The Poisoning of America's Children: Lead Exposure, Children's Brains and the Ability to Learn*** (Occasional Paper #6) — Dr Herbert Needleman of the University of Pittsburgh provides a comprehensive overview of lead poisoning, presenting research that demonstrates the long and short-term effects of low level lead exposure on children's intellectual ability and social adjustment. (1992, $5)

___ ***Health/Education Collaboration: Insights Into Six Field Activities*** (Occasional Paper #5) — describes five NHEC-sponsored community initiatives and analyzes implications for future activities. (1992, $5)

___ ***Bridging the Gap: An Education Primer for Health Professionals/A Health Care Primer for Education Professionals*** (Special Report) — this two-part primer describes the health and education systems and how professionals from both fields can work collaboratively. (1992, $12)

___ ***At Risk Does Not Mean Doomed*** (Occasional Paper #4) — Craig T. Ramey and Sharon L. Ramey, Co-Directors of the Civitan International Research Center of the University of Alabama at Birmingham, analyze the results of their research in early intervention programs for children. The research not only shows that these programs can significantly improve school readiness, but moreover demonstrates that certain types of children are in greater need of early intervention. (1992, $5)

___ ***Creating Sound Minds and Bodies: Health and Education Working Together*** (Special Report) — examines health/education policy environments and suggests collaboration at the federal, state and local levels; catalogues ongoing activities and provides an annotated bibliography of resources. (1992, $10)

___ ***Cocaine-Exposed Children: A Growing Health/Education Issue*** (Occasional Paper #3) —provides an overview of how cocaine and general drug use during pregnancy affect the health and ultimate learning potential of infants; offers action steps to help prevent the problems associated with drug exposure during pregnancy. (1992, $5)

___ ***"Help Me Learn, Help Me Grow"/"Ayudame A Aprender, Ayudame A Crecer"*** (Project Materials) —a bilingual, multimedia, parent awareness project. Materials are designed to be administered by professionals to help educate parents on the link between their child's health and education. [Starter Set — 1 video (Spanish, English), 40 posters, primers (Spanish, English, or mixed), 20 magnet notepad sets, 1 community action guide — $28 — *note: circle desired language of materials*] **Items are also sold individually.**

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___ Spanish starter set (Spanish video)
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___ # Spanish posters

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